06106

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (LFa)

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH:
County: Harford
City or town: Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year.
Hospital, institution, or street address where death occurred: 508 W. Bel Air Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pennsylvania County:
City or town: Phila. Pa.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1824 Mt Vernon St.,
(If rural, give LOCATION)
2.(a) If veteran, name war: None V

3.(a) FULL NAME: Archibald Alexander Anderson

3.(b) Social Security Number: 716-07-9798

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Ida Mackie
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): May 15 1872

8. AGE: Years: 73 | Months: 1 | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Princeton, N. J. (Town, county, and state)
10. Usual occupation: Penna R.R. Social Security Agt.
11. Industry or business:
FATHER 12. Name: Leonard Anderson
13. Birthplace: Princeton, N. J.
MOTHER 14. Maiden name: Mariah Hunt
15. Birthplace: Princeton N. J.
16. Informant: Mrs. L. B. Diederich
Address: 508 W. Bel Air Ave.
17. Removal (Burial, cremation, or removal. Which?) Date thereof June 18 1945 (month) (day) (year)
Cemetery or crematory: Princeton
Location: Princeton N. J.
18. Funeral director: Henry Tarring & Sons
Address: Aberdeen, Md.
19. June 18 1945 (Date rec'd by registrar) Nellie F. Gilroy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 15 1945 at 6.32 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5 1945, to June 15 1945; and that I last saw him alive on June 15 1945.

Immediate cause of death	DURATION
Cerebral Embolism	1 day
Due to: Cerebral hemorrhage	1 week
Due to: Malignant hypertension	10 years
Other conditions: Chronic interstitial nephritis	10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: James Corbett Hall M.D. M. D. or other
Address: Hanover, New Hampshire Date signed: June 16 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUL 7 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

06107

CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH:
County Harford
City or town Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William Campbell Bargar

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Hattie Bargar
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 1 1862

8. AGE:

Years	Months	Days	If less than one day
82	7	24	..... hrs. ..... min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual occupation Bricklayer & Builder
11. Industry or business
FATHER 12. Name Henry Bargar
FATHER 13. Birthplace Baltimore Md
MOTHER 14. Maiden name Elizabeth Anderson
MOTHER 15. Birthplace Pennd
16. Informant Katherine Magness
Address Aberdeen Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 28 1945 (month) (day) (year)
Cemetery or crematory Aberdeen Methodist
Location Aberdeen Maryland
18. Funeral director Howard K. McComas Sons
Address Aberdeen Md
19. June 28 1945 (Date rec'd by registrar) Maire M. Mondelale Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1945, at 7:30 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw him alive on June 24 1945

Immediate cause of death	DURATION
Pernicious anemia	9 yr
Due to	
Due to	
Other conditions Pv	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Jesse O Hodson M.D
M. D. or other
Address Edgewood, Md Date signed 6-25-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 30 1945
BUREAU V.S.

T 06198

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (P-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 180

VS A15 (T) (1) (M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County Harford
City or town Abingdon
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Abingdon
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Margaret Ellen Barr

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife William E.S. Barr
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Mar. 4, 1875

8. AGE: Years	Months	Days	If less than one day
70	2		hrs. min.

9. Birthplace Chesapeake City, Md (Town, county, and State)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Robert Donaldson
13. Birthplace Maryland
MOTHER 14. Maiden name Margaret R. Price
15. Birthplace Maryland
16. Informant Mrs. Florence B. Wightson
Address Abingdon Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 4 1945 (month) (day) (year)
Cemetery or crematory Bethel
Location Cecil County Maryland
18. Funeral director Howard R. McCormick
Address Abingdon Md
19. June 3 1945 (Date rec'd by registrar) Marie M. Mendenhall Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1945, at 12:05 A.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1943 to May 1945
and that I last saw h[illegible] alive on May 25 1945

	DURATION
Immediate cause of death Cerebral Hemorrhage	3 days
Due to Arterio sclerotic C-V. Disease	4 yrs
Due to Arterio sclerotic Hypertensive disease	4 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Ralph Hanby M.D. M. D. or other
Address Churchville Md Date signed June 1

REC
JUN 5 1945
BUREAU V.S.

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15-2)

CERTIFICATE OF DEATH

6109

Reg. Diat. No. 185

1. PLACE OF DEATH:
County: Harford
City or town: Rural - Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2.
Hospital, institution, or street address where death occurred: Havre de Grace R.D. #1
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Rural - Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. Havre de Grace R.D. #1
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Hortence Irene Bishop

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Black	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 2, 1945

8. AGE: Years 0 | Months 1 | Days 14 | If less than one day: hrs. min.

8. Birthplace: Harford Co. Md.
(Town, county, and state)

10. Usual occupation: —

11. Industry or business

FATHER — 12. Name: Oscar Bishop
13. Birthplace: Md.

MOTHER — 14. Maiden name: Sarah Bond
15. Birthplace: Md.

16. Informant: Mr. Oscar Bishop
Address: Havre de Grace, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 17, 1945 (month) (day) (year)
Cemetery or crematory: Grace Hill
Location: Harford Co.

18. Funeral director: R. Madison Mitchell
Address: Havre de Grace, Md.

19. June 16, 1945 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 16, 1945, at 2:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 2, 1945, to June 16, 1945

and that I last saw her alive on June 16, 1945

Immediate cause of death	DURATION
Patent foramen ovale	1 hr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James Urchert M.D.
M. D. or other
Address: Havre de Grace, Md. Date signed: June 16

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JUN 19 1945
BUREAU V.M.

(M) (I) (T)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(1) IF WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19)

CERTIFICATE OF DEATH

T

06110

Reg. Diat. No. 695

1. PLACE OF DEATH:

County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day - 45 Mos.

Hospital, institution, or street address where death occurred: Harford Memorial Hospital

How long in hospital or institution? 1 day - 45 Mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Aberdeen Md.

(If ontside city or town limits, write KURAL and give nearest town)

Street No. 206 Ryland Drive

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Baby Girl Bloomfield

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	S.

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) June 5, 1945

8. AGE:

Years	Months	Days	If less than one day
		1	hrs. 45 min.

9. Birthplace Havre de Grace, Harford Co. Md. (Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER 12. Name Irwin M Bloomfield

13. Birthplace Canada

MOTHER 14. Maiden name Ruth Okner

15. Birthplace Chicago, Ill

16. Informant Ruth Bloomfield (Mother)

Address 206 Ryland Drive Aberdeen

17. Buried (Burial, cremation, or removal. Which?) Date thereof June 9 1945 (month) (day) (year)

Cemetery or crematory Angel Hill

Location Havre de Grace, Md.

18. Funeral director P. Madison Mitchell

Address Havre de Grace, Md.

19. June 9 19 45 (Date rec'd by registrar) G. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-6 1945, at 7:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-5 1945, to 6-6 1945 and that I last saw ex alive on 6-6 1945

Immediate cause of death	DURATION
Prematurity (5½ mo)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles W Legum M.D. M. D. or other

Address Havre de Grace Md. Date signed 6-7-45

RECEIVED
JUN 11 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 55-2 7n

CERTIFICATE OF DEATH

06111

Reg. Diat. No. 181

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Harford
City or town: Perryman
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 62 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Perryman
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: no.

3.(a) FULL NAME: Edward George Bowser

3.(b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Helen Johnson
6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): March 7, 1883

8. AGE: Years	Months	Days	If less than one day
62	4		hrs. min.

9. Birthplace: Perryman, Harford Co. Md.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:
FATHER 12. Name: Josephus Bowser
13. Birthplace: Maryland
MOTHER 14. Maiden name: Semelia Clark
15. Birthplace: Maryland
16. Informant: Mrs. Helen J. Bowser
Address: Perryman Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 29 1945 (month) (day) (year)
Cemetery or crematory: Edmond M.E.
Location: Near Aberdeen
18. Funeral director: Henry Taxrina & Sons
Address: Aberdeen Md.
19. June 29 1945 (Date rec'd by registrar) Nellie F. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 27 1945, at 4A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ——— 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Carcinoma thyroid	6 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ... Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury: ... Injured at work?

23. SIGNATURE: Gerald C. Palmer M.D.
Personally (Medical Examiner, C. M. D., or other)
Address: Bel Air, Md. Date signed 6/27/45

RECEIVED
JUL 7 1945
BUREAU V.S.

06112

CITIES CORPORATE LIMITS ONLY

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (BFA)

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Harford Memorial Hospital
How long in hospital or institution? Adm May 26, 1945

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County
City or town Fallston
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Samuel Buckham

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
(?) 60			hrs. min.

9. Birthplace Harford Co. Md. (Town, county, and state)
10. Usual occupation laborer
11. Industry or business
FATHER 12. Name Robert Buckham
13. Birthplace Harford Co. Md.
MOTHER 14. Maiden name Matilda Mathews
15. Birthplace Harford Co. Md
16. Informant Hospital record. Address Havre de Grace, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/20/45 (month) (day) (year)
Cemetery or crematory Tabernacle Cem.
Location Near Belair Md.
18. Funeral director Hankey & Sons
Address Near Bel Air Md.
19. June 19 1945 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1945 at 7 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 26 1945 to June 18 1945
and that I last saw him alive on June 18 1945

Immediate cause of death	DURATION
Cardiac Decompensation	
Due to Chronic interstitial	
Due to Nephritis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other
Address Havre de Grace Md. Date signed 6-19-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 21 1945
BUREAU V P

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (BPA)

CERTIFICATE OF DEATH

06113

Reg. Dist. No. 185

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 554 Revolution St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 554 Revolution St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William Henry Burlark (Burlock)

3.(b) Social Security Number 579-10-7936

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	Married

6.(b) Name of husband or wife Frances Monk
6.(c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Apr. 7, 1897

8. AGE: Years 48 | Months 2 | Days 10 | If less than one day ..... hrs. ..... min.

9. Birthplace Ill. (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business

FATHER
12. Name George Burlark
13. Birthplace Ill

MOTHER
14. Maiden name Unknown
15. Birthplace Ill

16. Informant Mrs. Frances Burlark
Address 554 Revolution St Havre de Grace Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 19 1945 (month) (day) (year)
Cemetery or crematory Swan Creek
Location Harford Co. Md
18. Funeral director R. Madison Mitchell
Address Havre de Grace, Md.

19. June 19 1945 (Date rec'd by registrar) C. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1945 at 4 15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to June 17 1945
and that I last saw alive on June 17 1945

Immediate cause of death	DURATION
Chronic Interstitial Nephritis	9 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Claude L. Lawson M.D. M. D. or other
Address Havre de Grace Date signed 6-18-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH INDELIBLE INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 24 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

06114

Reg. Dist. No. 185-

WITHIN CORPORATE LIMITS OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution or street address where death occurred:
Harford Memorial Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Forest Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Nathan R. Carter

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 3, 1867

8. AGE: Years	Months	Days	If less than one day
78	7	21	..... hrs. ..... min.

9. Birthplace: Forest Hill, Harford Co., Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name: Nathan R. Carter
13. Birthplace: Maryland

MOTHER 14. Maiden name: Minnie ?
15. Birthplace: Maryland

16. Informant: Nathan R. Carter
Address: Forest Hill, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 27 1945 (month) (day) (year)
Cemetery or crematory: Rock Spring Cem
Location: Harford Co Md
18. Funeral director: H. S. Bailey
Address: Darlington, Md

19. June 25 1945 (Date rec'd by registrar) G. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 24 1945, at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 22 1945 to June 24 1945 and that I last saw h... alive on June 24 1945

Immediate cause of death	DURATION
Cerebral Hemorrage	
Due to Hypertensive cardio-vascular disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: G B Eastman M.D.
M. D. or other
Address: Aberdeen Md Date signed: 6-24-45

RECEIVED
JUN 28 1945
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

06115

Reg. Dist. No. 182

1. PLACE OF DEATH:
County: Harford
City or town: Bel Air, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Fountain Green Hospital
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Darlington, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Minnie D. Creswell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: George Creswell
6.(c) If alive, give age: 80 years

7. Birth date of deceased (mo., day, yr.): April 29, 1873

8. AGE: Years	Months	Days	If less than one day
72	1	18	...hrs. ...min.

9. Birthplace: Harford County, Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: George Gorrell
13. Birthplace: Harford County, Md.

MOTHER
14. Maiden name: Charlotte Divers
15. Birthplace: Harford County, Md.

16. Informant: George Creswell
Address: Darlington, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 20-1945 (moeth) (day) (year)
Cemetery or crematory: Darlington cemetery
Location: Darlington, Md.

18. Funeral director: Hubert P. Harkins
Address: Delta, Pa.

19. 6/18/45 (Date rec'd by registrar) Priscilla Fowwood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 17th 1945 at 11:54 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 1945 to June 17 1945 and that I last saw her alive on June 14 1945

Immediate cause of death	DURATION
CEREBRAL HEMORRHAGE	9 da.
TERMINATING AN	
Due to ESSENTIAL HYPERTENSION	8 yr.
Due to	
Other conditions CHR. OSTEO-ARTHRITIS	3 yr.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Willard P. Hudson M. D. or other
Address: Forest Hill Md. Date signed 6/18/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 21 1945
BUREAU V. R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (162-P)

CERTIFICATE OF DEATH

06116

Reg. Dist. No. 182

1. PLACE OF DEATH

County Harford

City or town Bel Air

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Harford

City or town Bel Air Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 615 Conowingo Rd

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Sallie M. Wanenhower

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife William W. Wanenhower

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 1 1869

8. AGE: Years 76 | Months 4 | Days 14 | If less than one day ..... hrs. ..... min.

9. Birthplace Washington D. C. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Barnett T. Swart

13. Birthplace Washington D. C.

MOTHER 14. Maiden name Sarah A. Bryan

15. Birthplace Washington D. C.

16. Informant Mrs. Adelaide Grant

Address 615 Conowingo Rd Bel Air Md

17. Transportation (Burial, cremation, or removal. Which?) Date thereof June 17 1945 (month) (day) (year)

Cemetery or crematory Lee's Funeral Home

Location Fourth + Wash. Ave. N.E. Washington D.C.

18. Funeral director Howard R. McComas Son

Address Aberdeen Md

19. 6/17/45 (Date rec'd by registrar) 19..... Priscilla Forwood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1945, at 8.05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1943, to June 1945

and that I last saw h.er alive on June 11 1945

Immediate cause of death	DURATION
Senile degeneration —	4 years
Due to Age and sedentary life	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. M. Hopkins M. D. or other

Address Bel Air Md Date signed 6/16/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JUN 21 1965
BUREAU V.R.

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-C)

06117

CERTIFICATE OF DEATH

Reg. Dist. No. 18-

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? eight years.
Hospital, institution, or street address where death occurred:
Harford Memorial Hospital
How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 310 N. Stokes St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Ellwood Deckman

3.(b) Social Security Number None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife Tenie Deane Deckman
6.(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) January 17, 1881

8. AGE: Years	Months	Days	If less than one day
64	5	12	hrs. min.

9. Birthplace Street, Harford Co. Md. (Town, county, and state)
10. Usual occupation Paper-hanger
11. Industry or business

FATHER
12. Name James P Deckman
13. Birthplace Street, Maryland

MOTHER
14. Maiden name Mary Thompson
15. Birthplace Harford Co., Maryland

16. Informant Viola Deckman
Address 310 N. Stokes St. Havre de Grace Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 2 - 1945 (month) (day) (year)
Cemetery or crematory Dublin Cem.
Location Dublin - Md.

18. Funeral director A. D. Bailey
Address Darlington - Md

19. June 29 1945 (Date rec'd by registrar) C. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1945, at 12 10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17 1945, to June 29 1945 and that I last saw him alive on June 28 1945

Immediate cause of death	DURATION
Hernia - Cardiac decompensency	
Due to Infection & undetermined origin.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury Injured at work?

23. SIGNATURE C. L. Lewis M.D. M. D. or Other
Address Havre de Grace Md. Date signed 6-29-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JUL 2 1945
BUREAU V. I.

CITIES CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-0)

CERTIFICATE OF DEATH

06118

Reg. Dist. No. 185

1. PLACE OF DEATH:

County Harford

City or town Havre de Grace, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs.

Hospital, institution, or street address where death occurred:
St. Francis Villa

How long in hospital or institution? 5 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Harford

City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)

Street No. Commerce & Market
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Sr. Mary Nazarine Christina Doemling

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 12 - 1872

8. AGE: Years	Months	Days	If less than one day
72	9	7	hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Teacher

11. Industry or business

FATHER
12. Name Joseph A. Doemling
13. Birthplace Germany

MOTHER
14. Maiden name Catherine Gutberlet
15. Birthplace Germany

16. Informant Sister Redemptus
Address St. Francis Villa, Havre de Grace

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/28/45 (month) (day) (year)

Cemetery or crematory Holy Redeemer

Location Baltimore, Md.

18. Funeral director Pennington & Son

Address Havre de Grace, Md.

19. June 27 19 45 (Date rec'd by registrar) G. L. Levia M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 19 45 at 7:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 2 19 40 to June 26 19 45 and that I last saw h[illegible] alive on June 26 19 45

Immediate cause of death	DURATION
Acute Dilatation	
Hypertension	
Due to Chronic Nephritis	
Diffuse	
Due to Carcinoma	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles J. Foley M.D. M. D. or other

Address Havre de Grace, Md. Date signed 6/29/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 29 1945
BUREAU F.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

06128

Reg. Dist. No. 182

1. PLACE OF DEATH:
County: Harford
City or town: Near Bel Air Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Near Bel Air, Md (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Cora Mae Dolan

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 7 - 1930

8. AGE: Years: 15 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Bel Air, Md (Town, county, and state)

10. Usual occupation: School

11. Industry or business

FATHER
12. Name: William E Dolan
13. Birthplace: Bel Air, Md

MOTHER
14. Maiden name: Flora E Sheppard
15. Birthplace: NC

16. Informant: Wm E Dolan
Address: Fallston Md RD 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 21 1945 (month) (day) (year)
Cemetery or crematory: Mt Carmel Methodist
Location: Emmorton, Md

18. Funeral director: Deaver Foster
Address: Bel Air Md

19. 6/19 19 45 Priscilla Fawcett
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 18 19 45, at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Electrical burns	instant
Due to	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 6/18/45
Where did injury occur? Bel Air (City or town) Harford (County) md (State)
Injured at home, farm, industry, public place (where?) Farm
Means of injury: Hit by lightening Injured at work? no

23. SIGNATURE: Gerald C Palmer M D
DEPUTY MEDICAL EXAMINER
M. D. or other
Address: Bel Air Md HARFORD COUNTY Date signed 6/19/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 21 1945
BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

06119

Reg. Dist. No. 182

1. PLACE OF DEATH:
County Harford
City or town Near Lynch's Corner Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Harford
City or town Lynch's Corner Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Elizabeth Miranda Doxen

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband or wife Jacob A Doxen
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 27-1867

8. AGE: Years 77 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Harford Co.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER
12. Name Hollin Beaumont
13. Birthplace Md

MOTHER
14. Maiden name Mary Jane English
15. Birthplace Md

16. Informant Mrs Brown Nee Kirk
Address Fallston

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof June 29/45
(month) (day) (year)

Cemetery or crematory Mt Zion
Location Fountain Green, Harford Co. Md

18. Funeral director Dean & Scales
Address Bel Air Md

19. 6/28/45 Priscilla Fawood
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 19 45, at 605 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 15 19 42, to June 26 19 45
and that I last saw her alive on June 20 19 45

Immediate cause of death	DURATION
Arteriosclerotic C V disease	3 yrs
Due to	
Due to	
Other conditions Hemiplegia	3 years

(Include pregnancy within 3 months of death)

Major findings at operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Gerald C Palmer M.D.
M. D. or other
Address Bel Air Md. Date signed 6/26/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUL 3 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (178-4)

T 06120

CERTIFICATE OF DEATH

Reg. Diat. No. 180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: Harford
County
Edgewood
City or town
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 Cedar St
Hospital, Institution, or street address where death occurred:
1 Day
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Alabama County Henry
City or town Headland
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mabel Katherine Eagle

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Wade Preston Eagle
6.(c) If alive, give age 25 years

7. Birth date of deceased (mo., day, yr.) Aug 1 1921

8. AGE: Years	Months	Days	If less than one day
23	10	1	hrs. min.

9. Birthplace Headland Ala
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Alto V. McElenny
13. Birthplace Henry Co Ala
MOTHER 14. Maiden name Cora Davis Milner
15. Birthplace Henry Co Ala
18. Informant Capt Wade P. Eagle
Address Edgewood Arsenal Md E. W. School
17. Transportation (Burial, cremation, or removal. Which?) Date thereof June 3 1945 (month) (day) (year)
Cemetery or crematory Headland Mortuary
Location Headland Ala
18. Funeral director Howard K. McConnaughey
Address Aberdeen Maryland
19. June 3 1945 (Date rec'd by registrar) M. M. Mendedale Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1945 at 3P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Carbon monoxide Poisoning	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 6/2/45
Where did injury occur? Edgewood Harford Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) 13 Cedar St Edgewood
Means of injury Gas stove on in house - unlighted Injured at work? No

23. SIGNATURE Gerald C. Palmer M.D.
Deputy Medical Examiner
Harford County
Bel Air Md
M. D. or other
Address Date signed 6/2/45

RECEIVED
JUN 5 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (MA)

CERTIFICATE OF DEATH

Reg. Dist. No. 06121 180

1. PLACE OF DEATH:
County: Harford
City or town: Edgewood
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 13 Cedar Street
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Alabama County: Henry
City or town: Headland
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Wade Hampton Eagle

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 22 1944

8. AGE: Years: 1 Months: 4 Days: 10 If less than one day: hrs. min.

9. Birthplace: Headland, Alabama, Henry Co. (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Wade P. Eagle
13. Birthplace: Alabama

MOTHER
14. Maiden name: Mabel K. Milner
15. Birthplace: Alabama

16. Informant: Capt Wade P. Eagle
Address: Edgewood Arsenal, Md. C.W. School

17. Transportation (Burial, cremation, or removal. Which?) Date thereof: June 3 1945 (month) (day) (year)
Cemetery or crematory: Headland Mortuary
Location: Headland Alabama

18. Funeral director: Howard K. McCormack Son
Address: Aberdeen Md

19. June 3 1945 (Date rec'd by registrar) Marie M. Mauldin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 2 1945 at 3P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__ to ____ 19__
and that I last saw h__ alive on ____ 19__

Immediate cause of death	DURATION
Carbon monoxide Poisoning	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 6/2/45
Where did injury occur? Edgewood Harford Md. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): 13 Cedar St.
Means of injury: Gas stove in house - unventilated Injured at work? no

23. SIGNATURE: Gerald E. Palmer M.D. Deputy Medical Examiner Harford County
Address: Bel Air, Md. M. D. or other
Date signed: 6/2/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 5 1945
BUREAU V. S.

Evidence for change of age is shown on

FILM No. G 96 JUN 29 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (12)

CERTIFICATE OF DEATH

06122

Reg. Dist. No. 182

1. PLACE OF DEATH:
County: Harford Md
City or town: Near Bel Air Md Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Bel Air (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war.

3.(a) FULL NAME Lorraine G Edwards

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 2-1927

8. AGE: Years	Months	Days	If less than one day
17 -11-			hrs. min.

9. Birthplace: Bel Air, Md (Town, county, and state)
10. Usual occupation: School
11. Industry or business

FATHER
12. Name: G Robert Edwards
13. Birthplace: N.C.

MOTHER
14. Maiden name: Dorsie M Byrd.
15. Birthplace: N.C

16. Informant: Mr G Robert Edwards
Address: Fallston

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 21/45 (month) (day) (year)
Cemetery or crematory: Methodist
Location: Perry Hall Balto. Co., Md
18. Funeral director: Dean & Foster
Address: Bel Air Md

19. 6/19 19 45 Priscilla Forwood
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 18 19 45, at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ——— 19—, to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Electrical burns	Instant
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 6/18/45
Where did injury occur? Bel Air Harford Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Farm
Means of injury: Struck by lightening Injured at work? no

23. SIGNATURE: [illegible] M. D. or other
Address: Bel Air Md Date signed 6/19/45

DEPUTY MEDICAL EXAMINER
HARFORD COUNTY

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

5

RECEIVED
JUN 21 1945
BUREAU V.E.

CITIES CORPORATE LIMITS ONLY

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

06123

Reg. Dist. No. 185

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 minutes
Hospital, institution, or street address where death occurred:
Harford Memorial Hospital
How long in hospital or institution? 45 Minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 214 Ryland Dirve
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Baby Boy Engle

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 23, 1945

8. AGE: Years ---; Months ---; Days ---; If less than one day: ---hrs. 45 min.

9. Birthplace: Havre de Grace, HarfordCo., Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Jesse J. Engle
13. Birthplace: Iowa

MOTHER
14. Maiden name: Clara Ethel Scott
15. Birthplace: North Carolina

18. Informant: Mrs. Clara E. Engle-Mother
Address: 214 Ryland Drive-Aberdeen, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/24/45 (month) (day) (year)
Cemetery or crematory: Angel Hill
Location: Havre de Grace
18. Funeral director: Pennington & Son
Address: Havre de Grace, Md.
19. June 24 – 19 45 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 23 19 45 at 12:30 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 23 19 45 to June 23 19 45 and that I last saw h-e-r alive on June 23 19 45

Immediate cause of death	DURATION
Immaturity	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: G B Jastram M D M. D. or other
Address: Aberdeen Md Date signed: 6-25-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15

RECEIVED
JUN 28 1945
BUREAU V.R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

06124

Reg. Dist. No. 18 5-

1. PLACE OF DEATH:

County: Harford

City or town: Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 days

Hospital, institution, or street address where death occurred: Harford Memorial Hospital

How long in hospital or institution? 17 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: 15 Street

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME George P. Forward

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife:

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 3-30-1874

8. AGE:

Years	Months	Days	If less than one day
71	2	15	..... hrs. ..... min.

9. Birthplace: Harford, Md. (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER 12. Name: Dallas Forward

13. Birthplace: Harford, Md.

MOTHER 14. Maiden name: Laura Smithson

15. Birthplace: Cecil, Md.

16. Informant: Deceased

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 16 1945 (month) (day) (year)

Cemetery or crematory: Rock Spring

Location: Harford Co., Md.

18. Funeral director: H. S. Bailey

Address: Darlington, Md.

19. June 13 (Date rec'd by registrar) 19 45 C. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6-13 19 45 at 5 00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-28 19 45, to 6-13 19 45 and that I last saw h.. alive on 6-13 19 45

Immediate cause of death	DURATION
Granulon	2 mo
Due to Adenocarcinoma of rectum	
Due to with metastases	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Charles H. Frigon M.D. M. D. or other

Address: Havre de Grace Md Date signed 6.13.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

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JUN 18 1945
BUREAU V.E.

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(1)

(T)

VS A15

(WITHIN CORPORATE LIMITS OF)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

06125

Reg. Dist. No. 185

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred: 3 Bourton St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 401 So. Union Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Wesley Carver Gibson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Doris E. Gibson
6.(c) If alive, give age: 29 years

7. Birth date of deceased (mo., day, yr.): Jan 25 1916

8. AGE: Years	Months	Days	If less than one day
35	4	7	— hrs. — min.

9. Birthplace: Havre de Grace, Md. (Town, county, and state)
10. Usual occupation: Secretary
11. Industry or business: Canning
FATHER 12. Name: Earnest Hopp Gibson
13. Birthplace: H. Co. Md.
MOTHER 14. Maiden name: Mary Elizabeth Hackney
15. Birthplace: Phila. Penn.
16. Informant: Mrs. Doris E. Gibson
Address: Havre de Grace Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 4 1945 (month) (day) (year)
Cemetery or crematory: Angel Hill
Location: Harford Co. Md.
18. Funeral director: T. Madison Mitchell
Address: Havre de Grace, Md.
19. 6-4 1945 A. L. Lewis M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 1 1945 at 2:10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1945, to June 1 1945 and that I last saw him alive on June 1 1945

Immediate cause of death	DURATION
Coronary Thrombosis	10 Minutes
Due to Arteriosclerosis of heart	1 Month
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Emma Wolbert M.D. M. D. or other
Address: Havre de Grace Date signed June 2 45

RECEIVED
JUN 6 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

06129

CERTIFICATE OF DEATH

Reg. Dist. No. 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Harford
City or town: Rural Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Churchville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: Frank J. Bertman

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Louie Fuller
6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): March 13-1868

8. AGE: Years	Months	Days	If less than one day
77	3		hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Retired

FATHER
12. Name: Frank J. Bertman
13. Birthplace: Germany

MOTHER
14. Maiden name: Susie Stanley
15. Birthplace: Germany

16. Informant: Mrs. Frank J. Bertman
Address: Aberdeen Md. R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 17-1945 (month) (day) (year)
Cemetery or crematory: Churchville
Location: Churchville Harford Co.

18. Funeral director: Benzy Sarring Sons
Address: Aberdeen, Md.

19. June 16 1945 (Date rec'd by registrar) Nellie F. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 15 1945, at 5.50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1939 to June 1945
and that I last saw h[illegible] alive on June 1 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	5 days
Due to Arteriosclerotic Hypertension	5 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Ralph Hurley M.D.
M. D. or other
Address: Churchville Md. Date signed June 15

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JUL 7 1945
BUREAU V.S.

06126

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (181)

CERTIFICATE OF DEATH

Reg. Dist. No. 185

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Harford
City or town: Edgewood Arsenal (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?: - -
Hospital, institution, or street address where death occurred: Station Hospital
How long in hospital or institution?: 20 hours

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: -
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 814 E. Coldspring Lane (12) (If rural, give LOCATION)
2.(a) If veteran, name war: - -

3. (a) FULL NAME: HOGAN, Amanda Lee Virginia Beaner

3. (b) Social Security Number: not known

4. Sex: F
5. Color or race: C
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Charles Walter Hogan
6.(c) If alive, give age: 66 years
7. Birth date of deceased (mo., day, yr.): 12 February 1911

8. AGE:

Years	Months	Days	If less than one day
34	4	18	...hrs. ...min.

9. Birthplace: Lovettsville, Louden, Virginia (Town, county, and state)
10. Usual occupation: Housewife and munitions handler
11. Industry or business: U. S. Government

FATHER
12. Name: Charles Henry Beaner
13. Birthplace: Lovettsville, Louden, Virginia

MOTHER
14. Maiden name: Nellie Gray
15. Birthplace: Lovettsville, Louden, Virginia

16. Informant: Mother, Mrs. Nellie G. Beaner
Address: - -

17. Burial (Burial, cremation, or removal, Which?) Date thereof: 7/3/45 (month) (day) (year)
Cemetery or crematory: Mt. Calvary
Location: A. A. County, Md.
18. Funeral director: Joseph G. Locks Jr
Address: 1304 N. Central Ave
19. 7/3 1945 (Date rec'd by registrar) H. W. Achcuk [?] MD. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 30 June 1945, at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 29 June 1945, to 30 June 1945 and that I last saw her alive on Saturday 1140AM 30 June 1945

Immediate cause of death: Burns, 3rd degree, both arms, chest, face, left side, left leg — DURATION: 18 hrs
Due to:
Due to:
Other conditions: Laceration of right cheek & Right Arm — 18 hrs. (Include pregnancy within 3 months of death)
Major findings of operations: —
Date of op.
Autopsy results: Burns, Cerebral edema, Nephrosis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accidental Date of: 29 June 1945
Where did injury occur? Edgewood Arsenal, Md. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Bldg. 503
Means of injury: White phosphorus Injured at work? yes.

23. SIGNATURE: James Walker Jr, 1st Lt. MC (M. D. or other)
Address: Med. Res. Lab. Edgewood Arsenal, Md. Date signed: 30 June 1945

VS A15

2 Transcript

06127

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (175-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH:

County: Harford

City or town: Aberdeen Proving Ground, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 months

Hospital, institution, or street address where death occurred:
Station Hosp, Aberdeen Proving Ground, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Mass. County: Unknown

City or town: South Deerfield
(If outside city or town limits, write RURAL and give nearest town)

Street No.: River Road
(If rural, give LOCATION)

2.(a) If veteran, name war: ---

3. (a) FULL NAME: KUZDEBA, PAUL

3. (b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Emma Jean

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 1, 1915

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
29	6	25		

8. Birthplace: Sunderland, Mass. (Town, county, and state)

10. Usual occupation: Laborer (soldier)

11. Industry or business: Trucking Company

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Poland

16. Informant: The Surgeon
Address: Sta Hosp, Aberdeen Proving Ground, Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof June 28, 1945 (month) (day) (year)

Cemetery or crematory: Wm. Lipmanke & Son

Location: 79 Thayer St. Deerfield Mass

18. Funeral director: Howard F. McThomas Son

Address: Arlington, Md.

19. June 30 1945 (Date rec'd by registrar) Nellie H. Giles Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 26, 1945 at 4:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 26 June 1945 to 26 June 1945 and that I last saw him alive on 26 June 1945

Immediate cause of death	DURATION
Shock, severe, secondary to (1) Traumatic amputation of the right forearm; (2) Compound	
Due to: fracture of the right humerus; (3) Compound, comminuted fracture	
Due to: of the right femur involving the knee joint with extensive loss	
Other conditions: of soft tissue; (4) Traumatic amputation of the 2d, 3d, 4th(a)	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 26 June 1945

Where did injury occur? Aberdeen Prov Grd. (City or town) Harford (County) Md. (State)

Injured at home, farm, industry, public place (where?): Military Reservation

Means of injury: Explosion of fuse Injured at work? Yes

23. SIGNATURE: F. K. Nichols
F. K. NICHOLS, Lt. Col., MC M.D. or other

Address: Sta Hosp, APG, Md. Date signed: 27 Jun 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(a) and 5th fingers of the left hand; (5) Penetrating wound through the right eye with foreign body intra cranial; (6) Multiple soft tissue wounds of the chest. 1,2,3,4, 5 and 6 were incurred by the accidental explosion of a fuse of undetermined type while working in Ordnance Warehouse, Aberdeen Proving Ground, Maryland, 26 June 1945

RECEIVED
JUL 7 1945
BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (407)

CERTIFICATE OF DEATH

T 06133

Reg. Dist. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Fallston
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Mary E. Lancaster (Lancaster)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	W	Widowed

6.(b) Name of husband or wife: Wm F Lancaster
6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): Aug 9, 1883

8. AGE: Years	Months	Days	If less than one day
61			hrs. min.

9. Birthplace: Md. (Town, county, and state)
10. Usual occupation: House wife
11. Industry or business

FATHER
12. Name: James Hanlon
13. Birthplace: Ireland

MOTHER
14. Maiden name: Margaret Dalton
15. Birthplace: Md.

16. Informant: Mrs Wm Lancaster
Address: Fallston, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 4 (month) (day) 1945 (year)
Cemetery or crematory: St Johns cem.
Location: Woodd Grove
18. Funeral director: Stuntzberger & Goos.
Address:

19. 6/2 1945 (Date rec'd by registrar) Priscilla Forwood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 1 1945 at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1 1945 to June 1 1945 and that I last saw h.e.r. alive on May 24 1945

Immediate cause of death	DURATION
Carcinoma Liver and Gall Bladder	
Due to: Carcinoma	
Due to:	
Other conditions: None	

(Include pregnancy within 3 months of death.)

Major findings of operations: no operation
Date of op.: no date
Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of: —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?): —
Means of injury: — Injured at work? —

23. SIGNATURE: W. M. Stirling M.D.
M. D. or other
Address: Fallston Md Date signed: 6/2/45

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JUN 5 1945
BUREAU V.S.

1944
6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

06130

Reg. Dist. No. 185-

WITHIN CORPORATE LIMITS OF

1. PLACE OF DEATH:

County Harford

City or town Havre de Grace Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No. 820 Otsego

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Adelina Reginald

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Samuel Reginald

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 23 - 1893

8. AGE: Years	Months	Days	If less than one day
51	2	1	..... hrs. ..... min.

9. Birthplace Italy (Town, county, and state)

10. Usual occupation Home Wife

11. Industry or business —

FATHER 12. Name Andrew Cuchinelli

FATHER 13. Birthplace Italy

MOTHER 14. Maiden name Unknown

MOTHER 15. Birthplace Italy

16. Informant Samuel Reginald

Address 820 Otsego, Havre de Grace

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/27/45 (month) (day) (year)

Cemetery or crematory M. Lin

Location Havre de Grace

19. Funeral director Pennington & Son

Address Havre de Grace Md.

19. June 26 - 1945 (Date rec'd by registrar) A. L. Lewis M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1945, at 11:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 1945, to June 27 1945; and that I last saw h... alive on June 27 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Hypertension	
Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Charles J. Foley M.D.

M. D. or other

Address 926 Pine St. Date signed 6/26/45

RECEIVED
JUN 28 1945
BUREAU V.E.

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

06131

★ Reg. Dist. No. 185

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 days
Hospital, institution, or street address where death occurred: Harford Memorial Hosp.
How long in hospital or institution? 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED: Cecil
(For newborn infants give residence of mother)
State: Maryland County: ~~Harford~~
City or town: Conowingo
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Elray Steele

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Married

6.(b) Name of husband or wife: Irene Steele
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Feb. 19, 1896

8. AGE: Years	Months	Days	If less than one day
49	4	11	hrs. min.

8. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Hotel Owner
11. Industry or business
FATHER 12. Name: Edward Steele
13. Birthplace: Maryland
MOTHER 14. Maiden name: Mary ?
15. Birthplace: Maryland
16. Informant: Irene Steele - Wife
Address: Conowingo, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 1, 1945 (month) (day) (year)
Cemetery or cremetory: Rudkin Cemetery
Location: Rudkin, Md.
18. Funeral director: H. S. Bailey
Address: Darlington, Md.
19. June 30 1945 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 29 1945, at 10 45 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 7 1945, to June 29 1945 and that I last saw him alive on June 28 1945

Immediate cause of death	DURATION
(a) Uremia	
(b) 2nd degree burns right arm, hand and face arm	
Due to burns right side, left arm and forehead	
Other conditions Due to explosion gas	
Stove	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) Harford (County) (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury: Injured at work? No

23. SIGNATURE: A. L. Lewis M.D. M. D. or other
Address: Havre de Grace, Md. Date signed 6-30-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUL 2 19
BUREAU V.R.

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (KO-0)

06132

CERTIFICATE OF DEATH

Reg. Dist. No. 18-

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Infant
Hospital, institution, or street address where death occurred: Harford Memorial Hospital
How long in hospital or institution? Infant

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Aberdeen (If outside city or town limits, write RURAL and give nearest town)
Street No. 3 Madison Place (If rural, give LOCATION)
2.(a) If veteran, name war: [illegible]

3.(a) FULL NAME: Baby Turner

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Infant

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 6-30-45-

8. AGE: Years | Months | Days | If less than one day: 3 hrs. min.

9. Birthplace: Md. Havre de Grace Md. (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business:

FATHER
12. Name: R. M. Turner
13. Birthplace: Texas

MOTHER
14. Maiden name: Dora Emma Duncum
15. Birthplace: Texas

16. Informant: R. M. Turner
Address: #3 Madison Place - Aberdeen Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof 7-3-45 (month) (day) (year)

Cemetery or crematory: Austin Texas
Location:

18. Funeral director: R. Madison Mitchell
Address: Havre de Grace Md.

19. July 1 1945 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-30 1945, at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-30 1945, to [illegible] 1945
and that I last saw h[illegible] alive on 6-30-45 1945

Immediate cause of death	DURATION
Probably Cerebral Hemorrhage	
Due to: Delivery	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

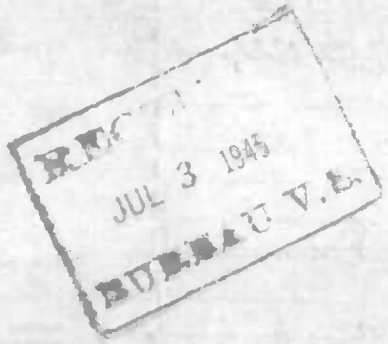
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: A. L. Lewis M.D. M. D. or other
Address: Havre de Grace Md. Date signed 6-30-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


JUL 3 1945
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45-P) 2

CERTIFICATE OF DEATH

06134

Reg. Dist. No. 181

1. PLACE OF DEATH:
County: Harford
City or town: Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? About 20 yrs
Hospital, institution, or street address where death occurred:
602 W. Bel Air Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
Street No. 602 Bel Air Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: Arend P. Wyckgraaf

3. (b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 6. 1868

8. AGE:

Years	Months	Days	If less than one day
77	3		hrs. min.

9. Birthplace: Baltimore City Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER
12. Name: Arend Wyckgraaf
13. Birthplace: Holland.

MOTHER
14. Maiden name: Rena Berends
15. Birthplace: Germany

16. Informant: Mrs. Ernest Volkart
Address: 602 Bel Air Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 8 1945 (month) (day) (year)
Cemetery ~~or crematory~~: St Pauls 5th Reform Church
Location: Baltimore Md.

18. Funeral director: Henry Tarring & Sons
Address: Aberdeen Md.

19. June 7 1945 (Date rec'd by registrar) Nellie H. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 6 1945 at 2 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 30 1945 to April 6 1945
and that I last saw h.~~im~~ alive on June 5 1945

Immediate cause of death: Cancer of Stomach — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H.C. Delany M. D. ~~or other~~
Address: Aberdeen Md Date signed June 7/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JUL 7 1965
BUREAU V. S.